USFHP Prior Authorization Request Form for Brexpiprazole (Rexulti)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Provider acknowledges that generic aripiprazole does not need a prior authorization and is available at a lower copay.	☐ Acknowledged Proceed to question 2	
2. What is the indication or diagnosis?	☐ Major Depressive Disorder – proceed to question **3** ☐ Schizophrenia – proceed to question **8** ☐ Alzheimer's Disease (AD) – proceed to question **11** ☐ Other – **STOP Coverage not approved**	
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication being prescribed by or in consultation with a psychiatrist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Will the requested medication be used concurrently with an antidepressant?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

USFHP Prior Authorization Request Form for Brexpiprazole (Rexulti)

6. Has the patient had treatment failure of at least TWO other formulary antidepressants? **Examples of antidepressants:** **a) SSRI (for example, citalopram, escitalopram, fluoxetine)** **b) SNRI (for example, venlafaxine IR, venlafaxine ER, desvenlafaxine succinate ER)** **c) TCA (for example, amitriptyline, desipramine, imipramine, nortriptyline)** **d) mirtazapine** **e) bupropion** **f) trazodone immediate-release** **g) nefazodone** **h) MAOI**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient had an inadequate response, intolerance, or contraindication to aripiprazole?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
8. Is the patient 13 years of age or older?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the requested medication being prescribed by or in consultation with a psychiatrist?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient had treatment failure of AT LEAST TWO other formulary atypical antipsychotics (ONE of which must be aripiprazole)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Is the patient 18 years of age or older?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient being treated for agitation associated with dementia due to Alzheimer's Disease (AD)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the requested medication prescribed by or in consultation with a neurologist, psychiatrist or specialist in geriatric medicine?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Have other causes of agitation been ruled out or treated?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Has non-pharmacologic management of agitation failed?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**

USFHP Prior Authorization Request Form for Brexpiprazole (Rexulti)

16. Is the provider aware that elderly patients with dementia-related psychosis treated with antipsychotic drugs are at increased risk of death?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

Prescriber Signature _____ Date _____

[15 July 2026]